Farmers' Market Nutrition Program Complaint Form

Name of Person Filing Complaint:		**Date:**	

Please Check One

☐ **Senior Participant** ☐ **Market Manager** ☐ **WIC/AAA Staff** ☐ **WIC State Agency**

☐ **WIC Participant** ☐ **Farmer** ☐ **WIC Agency and/or Clinic** ☐ **Other**

Participant ID #	**Farmer VendorID #**	**Agency/Clinic ID#**	**If Other, please describe**

Phone and/or Email:

Location and or Address:

Description of Complaint

Date of Incident: **Time of Day:**

Name or description of person(s) involved: (if applicable, provide participant ID # or Farmer Vendor # if available)

Location details: (include name , address and/or location)

Describe the incident in detail: (attach additional details, if needed)

Follow-up action requested:

Mail this form to:

California Department of Public Health
Women, Infants and Children (WIC) Program
Farmers' Market Nutrition Program
3901 Lennane Drive – MS 8600
Sacramento, CA 95834
Phone: (916)928-8513

or

Give this form to:

- Farmers' Market Manager
- Local WIC Clinic Staff
- Local Senior FMNP Coordinator